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Racial Aspects of Maternal and Child Health[1]

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FIRST-HAND knowledge of the health problems of Negro patients both in clinics and in private practice, and also some experience with Oriental patients, is the basis for the statements made in the present paper. So far as possible these statements have been substantiated by reference to the medical literature, but, especially in regard to minority groups other than the Negro, the gaps in the literature are surprising.

There are in continental United States about 12,000,000 Negroes, some 300,000 Indians, and more than 250,000 Orientals. If Alaska, Hawaii, and Puerto Rico are included, the numbers are even larger. Since the Mexicans in the United States also have special health problems, this nationality group of about 1,500,000 is included in this report. Together the nonwhite races and the Mexicans make up about 11 percent of the population.

The well-being of such a vast number of people is and should be of great importance to us. What is the health of these people? How does it compare with the health of the rest of the population? Are there racial differences?

The American Negro

At birth and at each age level the expectation for life of the Negro is markedly less than that of the white person. The Negro in 1931 had the expectation of life that the white person had in 1901 (*1*).

In 1930 (these figures are not yet available for 1940) the death rate for Negroes (18.0) was 82 percent higher than the death rate for white persons (9.9). The Negro city dweller had a death rate almost double that of the white city dweller. This is particularly significant in view of the huge migration of Negroes to the cities. Between 1910 and 1930, 1,500,000 Negroes moved from rural into urban areas. The high mortality rates hold true for all ages and for both sexes (*2*).

The Negro mother has less chance of surviving childbirth than the white mother, the maternal death rate for Negro women (90) being more than double the rate (44) for white women for the period 1936–38. A Negro baby has less chance of being born alive, the stillbirth rate for the Negro being more than twice that for the white race. If he arrives alive the Negro baby does not have the same chance of surviving the first year. In every State where there are 500 or more Negro live births per year, the mortality rate is higher for the Negro than for the white infant, and in one State the rate for Negroes is twice as high (*3*).

The great killer among Negroes as a whole is tuberculosis. The Negro death rate from tuberculosis is more than three times as great as that of the white population (*2*). For males between 10 and 14 years, the Negro rate is 11 times that of the white race (*4*). Tuberculosis is called the great white scourge, but in the United States it is the great black scourge.

For the incidence of syphilis almost any figure desired can be found in the literature. One

[1] Paper given at Southwest Regional Conference of Child Welfare League of America, St. Louis, Mo., November 7, 1940.

looking for extreme figures can find data that show syphilis to be alarmingly prevalent, but it is also possible to find figures which indicate that the frequency of syphilis among Negroes is far lower than many have supposed. One county survey shows that 40 percent of the Negroes are infected; another, less than 10 percent (*5*). The Army figures for the period of the World War, 1917–18, gave the syphilis rate as 6.5 percent for Negro and 1.3 for white soldiers. Figures based on cases under treatment in the general population indicate that the rate for Negroes is approximately twice as high as that for white persons. Syphilis in the Negro race, as in the white, raises the stillbirth rate, the rate of premature births, the infant mortality rate, and the death rate from cardiac disease.

For certain other diseases—pneumonia, influenza, heart disease—the incidence and mortality are greater among Negroes than among white persons (*4*).

All this goes to show that there are differences in health among racial groups in the United States. Why should these differences exist? There are two possible explanations: First, constitutional or physical differences on a hereditary basis; and second, environmental factors affecting health that are not operating equally for all groups. Take, first, hereditary difference in constitutional make-up. Let no one think that racial difference in susceptibility to disease implies "inferiority." There are certain sex differences in incidence of disease or abnormalities. Boys more frequently than girls have pyloric stenosis (a condition in which the opening from the stomach of an infant is too small) (*6*) and intussusception (a type of intestinal obstruction occurring in infancy) (*7*), and develop more frequently that clinical entity known as allergy. None of these sex differences means sex inferiority or superiority. The same holds true for racial differences, that is, for the few racial differences that are known to exist.

The Negro's susceptibility to tuberculosis and to respiratory diseases has long been used as evidence of "inferiority." The smaller lung capacity or so-called "tropical lung" of the Negro has been given as one explanation. Certainly the type of tuberculous infection seen in the Negro differs from that seen in the white person. The Negro has a more florid, fulminating type (*8*). Tuberculous meningitis is common among Negroes. Tuberculosis of the eyes is relatively rare among white children, but very frequent among Negro children.

The type of pulmonary tuberculosis found in the Negro today resembles that found among white persons a number of years ago. Perhaps this comparison reveals the reason for the Negro's so-called lack of resistance to tuberculosis, as any race or people coming in contact with a new infection is particularly susceptible to that infection. Immunity is built up by generations of contact. Tuberculosis proved a tremendous scourge to the American Indian as well as to the American Negro when introduced by the white race. There is evidence that the Negro, as the white man did before him, is gradually acquiring a higher degree of immunity. That tuberculous infection in the Negro produces a high state of allergy without a corresponding state of immunity is true. That this is the main cause of the high death rate is *not* true (*9*). Though a racial difference exists, its main application is in environmental factors.

What other diseases show differences that can be attributed to constitutional differences in races? Rickets might be counted as one. Rickets is much more severe in colored babies than in white babies in this country (*10*). Is this racial or environmental? Heavily pigmented persons probably absorb less of the antirachitic radiation than lighter-skinned people, it is true, but rickets is essentially unknown among Negroes of the West Indies, where sunshine is abundant. Italians, taken out of their native sunny climate and transplanted to New York, have almost as high an incidence of rickets as Negroes. Race itself is probably not the most important factor. Environmental factors must be held responsible.

The diet of the Negro child is high in carbohydrate to the relative exclusion of protective foods. Because of his dark skin he needs vitamin D in his diet even more than does the fair-skinned child. Lack of vitamin D in the Negro mother's diet may be one factor predisposing her infant to accelerated development of rickets.

Bad living conditions, overcrowding, and poor hygiene contribute to the production of rickets in the Negro child. Incidentally, the Eskimo, who spends a large part of his life without sunlight, protects himself from rickets by a diet high in fish oils. There is little evidence that rickets is influenced by race, save as race limits the individual's environment.

On the other side of the ledger there are several diseases for which the Negro has a greater immunity than the white man.

According to Dublin, whose figures are for Metropolitan Life Insurance Co. policyholders, there is undoubtedly less prevalence of diphtheria, scarlet fever, and German measles (and probably of measles) among Negro children than among white children, although once attacked by measles or diphtheria the Negro child shows less resistance than the white. Death from cancer of the skin is less common among Negroes. Diabetes occurs less frequently, though this difference in incidence in the white and Negro races is becoming less marked as more Negroes change from a rural to an urban environment. Infantile paralysis is less common among Negroes (*2*).

Congenital anomalies occur less frequently in Negro infants, but this may be due less to racial characteristics than to maternal age (*11*). The incidence of congenital anomalies for both white and Negro races increases with the age of the mother, and Negroes begin having babies sooner than white women and have a larger percentage of their children at an earlier age.

One very interesting racial difference is found in connection with syphilis of the central nervous system. Though syphilis is common among Negroes, both paresis and tabes are exceedingly rare (*5*), as they are also among Orientals.

To sum up, the racial differences in susceptibility to diseases that are known to exist are few, and not all to the disadvantage of the Negro. Tremendous differences in the health of the Negro and white races exist. Some of this difference may be truly racial, but most of it must be due to environmental factors and may be called the byproduct of race. It is not possible to separate hereditary from environmental factors until groups of white and Negro people can live in similar environments and be exposed to similar factors.

The earliest environment of the child is his intrauterine existence. The high maternal mortality among Negroes has been mentioned already, and the high stillbirth rate. Premature birth as indicated by weight is more common among Negroes, and is one among the many factors that raise the neonatal mortality rate. Negro children are smaller at birth than white children (*12*). It would be interesting to know whether size of the Negro infant at birth is related to economic status. With white children a recent study has shown that the birth weight of the infant and the length of the period it was carried are directly proportional to the family income (*13*). The Negro's handicap is apparent even at the beginning of his life, and coming into the world with a handicap, the Negro enters an environment unfavorable from every viewpoint.

In any enumeration of environmental factors that influence the health of any group of people, economic status stands first. Health, by and large, is a matter of dollars and cents. The income of the Negro, the Mexican, the Oriental in this country, even in good times, has been below the national average. For the same work the Negro is paid less than the white person. In the South, where four-fifths of the Negroes live and where incomes of the white population are low, the Negro has had barely a subsistence level. With the economic depression the Negro's income dropped even lower, and because he was already so low in the scale, it mattered even more to him. Charles Johnson has aptly called the Negro's status marginal (*14*). The Negro *is* marginal, in agriculture, in industry, even in domestic service. When we have an excess of labor the "margin" is wiped out.

In a variety of ways the low income of the Negro affects his health. It affects his health through the places in which he has to live. The inadequate Negro cabin of the South with its total lack of sanitary facilities is well known. In certain small towns and cities of the South where facilities are provided for garbage collection in white neighborhoods, no such facilities are provided for Negroes. In most large cities the sec-

tion assigned to Negroes is an old section, no longer desired by white residents, down at heel, insanitary, and frequently rat ridden. In proportion to what he gets the Negro pays a higher rent than the white person. And what he gets is usually the lowest type of home from a health point of view.

Perhaps the point where low income represents the greatest health hazard is in food purchase. Rickets, common among Negroes, could be prevented by adequate diet, including supplementary protective foodstuffs. Tuberculosis must be influenced to a large degree by the extensive malnutrition among Negroes. One hears, of course, that the Negro buys unwisely, that his proportionate consumption of grain and fats is too high. However, studies by the United States Department of Agriculture show no startling differences in food expenditure in relation to income between white and Negro families in the same geographic region (*15*).

Income bears directly on health by its control of the purchase of medical care. Medical care has a price, and good care has, as a rule, a high price. The Negro, like others who cannot afford good care, gets his medical care from the quack or over the drugstore counter. Even if he is able to pay, the facilities open to him are few. Many white members of the medical profession decline to serve Negro patients. Facilities for training Negro physicians are not adequate. Many medical schools refuse them admission. Many hospitals close their doors to Negro internes. Few public-health officials, though possessing funds for training, make plans for training Negro physicians.

In the background of the health picture for children may be seen certain forces other than economic. One of these which has a direct bearing on the Negro child is relative lack of family stability. Whatever the cause, the Negro family is less closely knit, less homogeneous, less stable than the average white family. The matriarchal character of the Negro slave family has survived to a large degree. The woman is still the focal point of the family, but she is also frequently the wage earner. In the cities she works, when she can get work, often from 7 o'clock in the morning to perhaps 8 o'clock at night, outside her home. Adequate care of her children is impossible, and they suffer in consequence. Migration of Negro families from rural to urban areas has brought its disintegrating force to the Negro family and has added its burden of health hazard.

As improved health follows a rising scale of income, so also health follows improved educational advantages. Though in some places educational opportunities for Negroes may be equal to those for white children, in other communities they are not. Especially in communities where separate schools for Negro children are maintained is the standard of education for the Negro children below the national average.

The Report of the Advisory Committee on Education (*16*) states:

> In most of the States where there are separate schools for Negroes, the schools for white children are below the national average, yet Negro schools are only about half as well supported as white schools. . . . All the statistics for length of school term, average attendance, educational qualifications of teachers, type of school buildings, and other factors indicate that a wasteful neglect is characteristic of the treatment of Negro school children in most of the areas where they are required to attend separate schools.

Illiteracy and superstition are still common. In a well-baby clinic in St. Louis many a Negro baby has a black velvet teething collar, costing 50 cents. That 50 cents spent on cod-liver oil would be much more effective in getting the teeth through. Many of the mothers just up from the South rely on less expensive charms made of white potatoes on a string, or pennies, or nuts. Not only do poor educational facilities leave great numbers in ignorance, but opportunities for special training for Negroes are so few that only the most ambitious achieve professional standing.

That communities fail to provide public-health facilities for Negro citizens is one of the major causes of difference in racial health records. Hospital facilities for Negroes are inferior, and in some communities nonexistent. Clinics are fewer and are less well-equipped and well-manned. That is not true of all cities, of course, but by and large it is true, especially in rural areas or small towns. Here the Negro must rely on private Negro physicians, inade-

quate in number and often poorly trained. There has been frequent comment on the exploiting of the Negro patient by the Negro physician. Some of it is true. But the Negro physician is up against the same problem as the white physician, that of combining altruism with making a living. Incomes sufficient to pay for medical care, which are possessed by few Negro patients at best, are wiped out in a depression, and the physician is left with the altruism but without the income. The problem of medical care for the low-income class remains unsolved for the Negro as for the white family.

Other Minority Groups

Of the health of other minority groups in the United States very little is known. About the Mexicans, who constitute the next largest group, few statistics are available. Certain States, California for one, have made some investigations and issued some reports. The Mexican, like the Negro, lives in a community made up of his own kind. In a large city the "Little Mexico" is an old area, representing a zone of transition, is disorganized, and usually is high in crime and delinquency. In the smaller community the Mexican lives in "camp" on the edge of town, these camps being of the most temporary structure and poorest sanitation possible. Because of the migratory nature of the Mexican's work—he is usually a railroad laborer or seasonal agricultural worker (*17*)—these camps seldom attain any permanency in construction or population. A Mexican woman described the hut to which her family was assigned by the railroad as one room and a small kitchen, in which 10 people lived. "All of us could not lie down at once," she said. "We slept in turns." Because of the disadvantages from which it suffers, Mexican family life is relatively unstable. The income of the Mexican family is low and the birth rate high. The infant mortality rate is high, in California being more than double the rate for the white population (*18*). The chief causes of death among the children under 1 year are communicable diseases, gastrointestinal diseases such as dysentery, and respiratory diseases, especially pneumonia. All these diseases, of course, are those influenced by poor living conditions. In the Mexican population as a whole tuberculosis is prevalent and the death rate high. The amount of syphilis among the Mexicans is not known. The health of Mexican laborers and their families is beginning to concern health authorities. Prenatal and child-health conferences have been organized in a number of counties with a large Mexican population. That Mexicans will accept health instruction is seen by the large numbers attending these clinics.

About the health of the American Indian little more is known than about the Mexican and much less than about the Negro. Statistics are unreliable because of poor reporting, and because of the frequency with which birth and death take place without the services of a physician. The mode of life on Indian reservations and the distance of these reservations from medical centers have discouraged research and investigation of Indian problems. Living conditions among the Indians on some reservations are extremely bad. Though one is accustomed to think of the Indian as a creature of the open spaces, his living conditions at night often resemble those of the worst city tenement.

Dr. Townsend, Director of Health, Office of Indian Affairs, estimates the life expectancy at birth for Indians at about 32 years. The maternal death rate is high, but complete figures are not obtainable because many women have no physician in attendance. Many of the deliveries are by ill-trained midwives. Childbirth is not simple and safe among primitive people (*19*). The infant death rate is at least double the rate for white infants, and on some reservations goes as high as 200 per 1,000 live births.

Tuberculosis, as with the Negro and Mexican, is the great killer. The Government now has 14 sanatoriums with 1,400 beds and 81 general hospitals which take care of 1,700 patients with tuberculosis. Trachoma is another great concern of the Office of Indian Affairs (*20*). In a few sections of the country there are groups of Indians who are entirely free from trachoma; in other sections the incidence is as high as 40 percent and perhaps even higher. In the early Government schools trachoma was spread by the mixture of children from noninfected and infected groups. With the isolation of infected

children in special schools and with improved methods of treatment, the amount of trachoma is decreasing. Reports from Government hospitals of the treatment of this disease with sulfanilamide are most encouraging (*21*). The Indian, contrary to popular belief, is accepting modern medical care, and his health thereby is improving.

The Outlook

Too gloomy a picture of the health situation of minority peoples in this country should not be painted. That opportunities for healthful living are unequal everyone should realize. To know that improvement is being made and how it is being made is of equal importance. The general mortality rate is going down in this country. The maternal rate and the infant rate are dropping more rapidly. That the maternal death rate for 1 year could be as much as 14 percent lower than that for the previous year is a very encouraging fact. But it is discouraging to learn that, though the death rate for Negro mothers is going down, it is not going down with as much speed as the rate for white mothers. High rates should be easier to reduce than low rates.

The health factors affecting minority groups are baffling to the forces of social planning not because of their peculiarity—American genius is sufficiently developed to deal with each of the health factors discussed in this paper. The promotional activities necessary to focus attention upon and to plan the abatement of ravaging health problems in minority groups are certainly not beyond the capacity of leadership in communities of the United States. It is through this leadership that American genius shows itself.

The improvement which is taking place in maternal and child health is the result of multiple forces that have come into play in the last 20 years. This is an era of *increasing awareness of social and economic problems.* People are interested in the welfare of their neighbors and are seeking and trying out plans for social improvement. *Education* involving the extent of health needs as well as how to meet them has taken a tremendous upswing. Reading matter for parents, motion pictures, and especially the radio are instructing a large percentage of the population day after day. *Medical science* has contributed its share in new discoveries, the most recent and most spectacular of which is the discovery of sulfanilamide and its derivatives, and their use in controlling many infections. But it is to *public-health activities* that a large share of the credit is due. (By "public" in this instance is meant not only those agencies under government auspices, but all agencies serving that portion of the population unable to pay for medical care.) Prenatal clinics and child-health clinics have been established in all parts of the country. Facilities which were once found only in large communities are going into rural areas and into small towns. The public-health nurse is a familiar sight now in many communities and is accepted as an integral part of any health program. With the enactment of the Social Security Act in 1935, States were enabled to extend and amplify their services to mothers and babies and to crippled children, including, more recently, children with cardiac defects. It is thrilling to know that all over the United States, in all our States and Territories, programs of maternal and child care are being carried out. The stories of these activities are varied in character and in scope and indicate the wide range in need and the boundless possibilities for service.

In Alaska the problem of tuberculosis among the Indians is a matter of great concern and is of increased importance in view of the defense plans for air bases in this region.

In the Southwest training of medical personnel is at present one of the main concerns. Those who are used to a large city with one or two or more good medical schools find it hard to visualize a group of five large States without one school among them. In two States there are no physicians certified as obstetricians by the American Board of Obstetrics and Gynecology. A method of training is being worked out to fit the needs of this region whereby physicians are sent to certain centers out of the State for training, and whereby a physician comes from the medical center to the State and acts as circuit rider, going from town to town and

helping the local physicians with their problems in their own offices.

In the Southeast is located one of the most interesting community projects in the country, the Slossfield Health Center (*22*) in Birmingham, where an effort has been made to replace "granny" midwives with well-trained physicians. In the area served by the clinic live about 50,000 Negroes. The staff, except for 4 white consultants, is Negro and is under the direction of a Negro pediatrician. There are clinics for tuberculosis, venereal diseases, dental care, and general medical diagnosis. The infant-health service includes not only feeding instruction and immunization but pediatric diagnosis and care for sick children. The maternity service is the most complete service in the center, offering prenatal care, home delivery or delivery in the hospital at the center if needed, and postnatal care. But the interesting thing about the center is that it offers not only service to the patients, but training facilities for physicians. The physician who holds the clinic or conducts the home delivery, is a neighborhood physician working under the direction of a trained consultant. The local physician is paid for his work and in addition receives special training. It is hoped that in time all the Negro physicians of this region will have an opportunity to receive training, and it may be that Negro physicians from other States will be sent to get instruction.

Projects such as these are a good beginning. But until a positive attitude is taken toward all health problems of minority groups in this country and until all groups are provided with equal opportunities for practicing "the art of life," the health of these minority groups will remain below the national average.

Ira de A. Reid has brought this out in a poignant passage of his book, In a Minor Key, prepared for the American Youth Commission:

> So, despite the proverb, death, too, is a respecter of persons. Its heavy hand does not fall with equal frequency on youth of all colors and origins. It takes the poor youth before the rich one, the foreign-born before the native-born, and the colored youth before the white, for the art of life can be practiced well only when external circumstances are moderately favorable.

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National Conference on Nutrition Organized

Leaders in the field of nutrition, education, public health, medicine, nursing, social work, home economics, agriculture, labor, industry, government, and community organization have been invited by Paul V. McNutt, Federal Security Administrator, to attend the National Nutrition Conference for Defense in Washington, May 26–28, 1941.

The Conference consists of several general sessions and two sessions for group discussion. Each section is expected to present to the final general session a report of its deliberation with proposals for recommendations to be made by the conference to the President.

The following sections have been organized:

1. Research and national nutrition problems:
   Dr. E. V. McCollum, chairman.
   J. Ernestine Becker, secretary.
2. Economic policy and social responsibility as related to nutrition:
   Lucy Gillett and Dr. Hazel Kyrk, chairmen.
   Dr. Hazel K. Stiebeling, secretary.
3. Public health and medical aspects of nutrition—(a) general; (b) mothers and children:
   Dr. James S. McLester and Dr. Richard Smith, chairmen.
   Dr. W. H. Sebrell and Dr. Katherine Bain, secretaries.
4. Nutrition for workers in defense industries:
   Dr. Frank G. Boudreau, chairman.
   Dr. Carroll Palmer, secretary.
5. Methods of education in nutrition:
   G. Dorothy Williams and Mrs. Mildred Weigley Wood, chairmen.
   Miriam Birdseye and Edna Amidon, secretaries.
6. Professional education in nutrition:
   Dr. Lydia J. Roberts and Dr. John H. Musser, chairmen.
   Dr. Thelma Porter and Marjorie Heseltine, secretaries.
7. Nutrition problems in distribution and processing of foods:
   Dr. Hector Lazo and Dr. L. V. Burton, chairmen.
   Dr. Frederick V. Waugh and R. S. Hollingshead, secretaries.
8. Community planning for nutrition—urban—rural:
   Dr. Howard McCloskey and Director H. C. Ramsower, chairmen.
   Marjorie Vaughn and Dr. B. W. Allin, secretaries.
9. Nutrition problems in group food service:
   Mrs. Katherine Ansley and Mrs. Alberta MacFarlane, chairmen.
   Melva Bakkie, secretary.

The introductory statement to delegates by M. L. Wilson, chairman, Nutrition Advisory Committee to the Coordinator of Health, Welfare, and Related Defense Activities, points out that some kinds of nutrition problems can be met successfully by the individual and the family, but that others must be solved through State or community action designed to achieve what families cannot manage by themselves. Since in many respects nutrition is a national problem requiring a national policy if food enough to insure health is to be provided for every citizen, the President of the United States is convening the National Nutrition Conference for Defense for the purpose of making recommendations for a Nation-wide program of action.

Health for Children in Vermont

The Montpelier Conference, February 11, 1941

By Elizabeth Morrison Wagenet

Executive Secretary, National Maternal and Child Health Council, Washington, D. C.

"Toward a hardy life" is fast becoming an American slogan under the growing urgency of the times. In Vermont the hardy life is an actuality already. But the ruggedness and individualism associated with Vermonters are not indicative of a static condition. Though the population has grown little over the years, the spirit of Vermont is one of growing and becoming, of acceptance of advances proved sound, of determination to make them a part of the soul and physique of the people.

Here, in essence, was the reason for the Statewide Conference, Health for Children in Vermont, held in Montpelier on February 11, 1941. Practically, the conference rested on the belief that any public-health program depends on the interest and support of the citizens: "Each Vermonter must know what is being done to protect and improve the health of mothers and children in our State," and the converse, "We, the administrators, must know what the people need and want from public services."

This was a 1-day conference, blessed with a bright sun and an "up to zero" temperature. Snow was on the ground, but the roads were fairly clear for driving. A holiday spirit was in the air, for it was "ladies' week" at the State capital, and wives, daughters, friends of the legislators were in town.

One-room schools, city schools, all had been working on projects and posters from which, with difficulty, 300 were selected to brighten the walls of the meeting place. The auditorium began to fill with men and women long before the opening hour. Nurses in uniform conducted conference goers to their seats. The janitors were sent for more chairs until the fire-law quota was reached. Then men and women stood!

Between 400 and 500 people came. Every county in Vermont was represented, and more than 80 towns. Fifty-seven organizations and departments of State work were represented. A fundamental interest in education, in wanting to know how to advance the good of the State, probably is characteristic of an independent farm population—and 90 percent of Vermont farms are operated by their owners. So the difficulties of travel in winter did not keep the Vermonters from carrying out the conference plan.

Was the program they came to hear worth the effort? It ranged from statements in regard to the health services provided by the Vermont State Department of Public Health to descriptions of how to raise money by entertainments and committees to get local health work under way. Among those who spoke were the chairman of the Vermont State Board of Health, the executive officer of the State Department of Public Health, members of the Maternal and Child Health Division, members of the State advisory committee, the president of the Vermont Medical Society, the professor of obstetrics at the University of Vermont, and superintendents of school districts. The Governor attended the evening session and spoke.

In the conference the national aspects of health for children in Vermont were not overlooked. Dr. Clara E. Hayes of the Children's Bureau, United States Department of Labor, discussed the subject, "Better Care for Mothers and Babies—State and Nation." From the Maternity Center Association in New York City came Hazel Corbin, general director, who spoke on the conference theme, "Mother—Child—Home—Community—State—Nation."

The National Maternal and Child Health Council,[1] an organization of 60 national organizations, had been asked by the State Ad-

[1] Formerly National Council for Mothers and Babies.

visory Committee to give consultation service and assistance in building the conference. The conference was sponsored by the advisory committee to the Maternal and Child Health Division of the Vermont State Department of Public Health, A. D. Lawton, chairman. Mrs. A. M. Gay assumed the responsibility of chairman of the steering committee for this conference.

Vermont has a reputation for understatement. To report that since the conference at least 11 new towns have appropriated money for health services is to understate the value of the conference. A flow of increased understanding and a solidifying of purpose will be the long-time gain. "Practical visions" was the topic of the evening session. Vermont children, their mothers and fathers, the communities they live in, and even the Nation should feel the benefit of this meeting either through direct contact with Vermont services for health, or through the ripples which carry in widening circles, enthusiasms, examples, convictions.

What Vermont Has Done[2]

By Clara E. Hayes, M. D.

Maternal and Child Health Division, U. S. Children's Bureau

Each year since the enactment of social-security legislation, Vermont has made a considerable increase in its expenditures for maternal and child-health work. Also the percentage of total expenditures drawn from State and local funds has increased each year, from 32 per cent in 1937 to 44 percent in 1940.

Under Vermont's first maternal and child-health plan submitted under the Social Security Act in 1936, the staff consisted of the director, 8 public-health nurses, and 3 dental hygienists. The plan for 1941 includes the director, a dental adviser, 2 full-time local dentists, a nutritionist, and 27 public-health nurses. It also provides for obstetric consultation in certain areas. The amount budgeted for payment to local practicing physicians and dentists for services to mothers and children at clinics and conferences has been increased 40 percent and consultation service by practicing obstetricians and hospitalization and medical treatment for children have been added.

Some results of the efforts on behalf of mothers and children can now be pointed out. In the period 1934–39 there occurred a decline of 32 percent in the maternal mortality rate in the United States, the greatest decrease ever recorded for a similar period in this country. With this decrease in mortality it is reasonable to believe that there has been a considerable decrease in illness and disability associated with maternity, but unfortunately we have no means of measuring this. The decrease in maternal mortality was accompanied by a decline of 20 percent in the infant death rate and 11 percent in the stillbirth rate.

In the State of Vermont during this period there was a decline of 8 percent in the maternal death rate, 13 percent in the infant death rate, and 18 percent in the stillbirth rate. The maternal and infant mortality and stillbirth rates are somewhat lower in Vermont than in the United States as a whole.

[2] Adapted from paper given at Conference on Health for Children in Vermont, Montpelier, February 11, 1941.

The Rural Child-Guidance Clinic

By John H. Waterman, M. D., *Director, and* Lorna S. Sylvester, *Psychiatric Social Worker, Tri-County Child Guidance Center, Harrisburg, Pa.*

Facilities for meeting the many social needs of individuals and groups are generally more numerous and adequate in large urban centers than in the smaller more rural communities. There are obvious reasons for this. In a large community, personal and social difficulties become more apparent and more acute because of the tempo of living and the problems involved in the interdependence of individuals. When these problems become evident in urban communities, large groups of citizens either directly or indirectly concerned become active in setting up social agencies to meet these needs.

The variation between urban and rural communities becomes particularly apparent in connection with specialized agencies such as child-guidance clinics. In some 30 years of child psychiatry in the United States interest has centered largely around child-guidance clinics located in great urban communities. Excellent progress has been made. However, the gain has not been proportionately so great for the country child as for the city child. Yet the need for psychiatric services for children in other than selected city areas is being recognized more and more clearly, as Witmer points out:

> We must study the changes that have taken place in the theory and practice of favorably situated clinics and consider their implications for work outside the protected area of urban child guidance. For the challenge of the present moment is that of discovering some means by which the kind of help that is available to the few patients of the best clinics can be offered to children throughout the country.[1]

[1] Witmer, Helen Leland; Psychiatric Clinics for Children, p. x. Commonwealth Fund, New York, 1940.

Psychological, diagnostic, and treatment services frequently are regarded by persons who are not socially interested and informed as less important than services providing maintenance and institutional care for children who present social problems. The neighborly responsibility that formerly characterized rural areas has decreased, but the transition to the acceptance of the professional, organized agency has not yet been completed. Individuals have not yet developed much willingness to give financial support to such organizations. The fact, too, that population is scattered makes the focusing of need in rural areas and, therefore, the focusing of financial support more difficult. Because the distance between families makes varied contacts impossible, individuals are aware only of isolated instances of need and, therefore, do not see the necessity for a planned program.

The scattered distribution of families also raises the question of location of facilities. It is impossible to place offices so that they will be easily accessible to all those in the area to be served.

Various methods of giving service within the limits of the community's desire for and ability to support it have been used. The traveling clinic sponsored or operated by State hospitals, universities, or private organizations has been one method. One difficulty in this method is due to the infrequency of the visits of the traveling clinic and the large number of children who must be seen in a few hours. The services rendered, therefore, may be limited primarily to tional growth is to take place. It is not always

logical examination, and one or two psychiatric interviews with the child and parents. The value of such service depends largely upon the case-work skill of the social worker who is to use the diagnosis as a basis for follow-up treatment.

With the recognition of these lacks, the Tri-County Child Guidance Center was established in Harrisburg in 1938. The approach to the problem of psychiatric care for children in rural areas differed in at least two important respects from the usual approach. The center was not to be a traveling clinic. Service was to be given to the three counties of Dauphin, Cumberland, and Perry at the office in Harrisburg, the business and geographic center of the area. From the beginning it was believed that utilizing the individual parent's recognition of his child's need for psychiatric service was more important than centering attention entirely upon interpretation to the community and would lead to greater use of the center. In this way knowledge and understanding of the value of the center's services would be built up slowly, individual by individual, but personal experience seemed to be the soundest basis for interpretation. The group using the center would become a nucleus for the development of awareness of need and understanding of child-guidance services in the rural area.

Any agency with such an interpretive and slowly developing program must have the kind of support which will be continuous and secure during the period of establishment. In order to accomplish this a second relatively new but sound concept was introduced. This was that treatment for individual children could reasonably be included in the general child-welfare program. Therefore, the center was established as a division of the rural child-welfare services of Pennsylvania, under title V, part 3, of the Social Security Act, which provides for services in rural areas "for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent."

As far as general plan and physical set-up are concerned, the center does not differ a great deal from other child-guidance clinics recognized as such by the Division on Community Clinics of the National Committee for Mental Hygiene. It is a full-time clinic devoted exclusively to the problems of childhood and combines the professional services of psychiatrist, psychiatric social worker, and psychologist. Complete diagnostic, psychological, and treatment services are provided. It is housed in separate quarters in a residential section of the city but still is easily accessible to the business center and to all routes leading to Harrisburg. It has a citizens' advisory committee or board composed of lay and professional persons chosen from the areas it serves and also a professional advisory committee composed of experts in the field of child guidance. The community participates in the financial support of the center through the welfare federation, the community chest organization of Dauphin County.

The major part of the center's budget is met from Federal funds appropriated under the Social Security Act and administered by the State. This gives security to the program and makes available services which rural areas either could not or would not support financially before they had had actual experience with them. The increased complexity of administration which this entails has not proved a serious handicap during the 3 years of the center's existence. Supervisory functions are exercised by the United States Children's Bureau and the Pennsylvania State Department of Welfare, within which are the Rural Child-Welfare Services, the Bureau of Mental Health, the Bureau of Community Work, the Comptroller, and the Secretary of Welfare. It is true that on occasion there has been a delay in carrying out an accepted plan or in obtaining qualified personnel, but in general, the center has actually profited by the introjection of ideas and interests of the various supervisory departments.

The center shares the accepted philisophy of most guild-guidance clinics, which is based on the recognition of a child's need for support from his environment and of the parent's responsibility for giving this support during the process of obtaining help for the child. It also recognizes the necessity for mutual understanding between child and parent if normal emotional growth is to take place. It is not always

the parent who brings the child to the center. There is one small group in which an agency is entirely responsible for the child. The foster parent or the case worker from the agency responsible for the child arranges for service and comes to the center for interviews or conferences at the same time that the child is being seen by the psychiatrist or psychologist.

The group in which the parent, or relative in parental role, makes application at the center for service, however, includes the majority of applications to the center. During the application interview with the social worker the parent decides whether he is willing to participate in this process and to what degree. This influences to some extent the kind of service which he requests for his child, although many other factors must also be taken into consideration.

The three types of service, that is, psychological study, diagnostic study, and treatment, differ from one another largely in terms of purpose and extent of service.

The psychological study of the child may consist of one to four periods with the psychologist. During these hours tests are administered to determine the child's innate ability or his particularized abilities, or his general social adjustment. Any or all of these tests may be given depending upon the particular problem of the child and upon the need for service as seen by the parent. The results of these tests and the way in which this additional knowledge may be used by the parent are discussed in interviews between parent and social worker.

The diagnostic study is similar except that in addition to the psychological tests the child has two or three interviews with the psychiatrist. Both these services are for diagnostic purposes as they afford information concerning a child's abilities, his social adjustment, his personality development, and the kind of support and help that the child needs from his environment.

The third type of service, treatment, is the one which particularly distinguishes the service of the Tri-County Child Guidance Center from other forms of psychiatric service available in rural areas. Treatment is the process of giving direct help to child and parent through regular weekly interviews at the center, child with psychiatrist and parent with social worker, for several months. During this period the child has, within the limits of the interview with the psychiatrist, an experience in living and learns with the help of the psychiatrist how to change some of his attitudes, how to relate his emotions to other people more satisfactorily, and how to become a little person who is able to live comfortably with others and yet maintain his own individuality. The parent in his or her interviews may find that there are adjustments which he must make if his child is to have an opportunity to grow up satisfactorily. He must learn how to give the child support in this developing process and how to maintain his part in the complex and meaningful parent-child relationship.

For the parent this is a great undertaking, because frequently he prefers to believe that his child should change while he himself remains unchanged or assumes no responsibility. If a parent is to be able to decide whether he wishes to participate in the treatment process it is necessary for a clinic to provide tangible points in relation to which the parent can become aware of his responsibility and indicate his willingness to assume it. At the Tri-County Child Guidance Center, the fact that parents must frequently come long distances to reach the center creates a realistic factor. In addition to the payment of fees, also used by other clinics as a focus for the acceptance of responsibility, there is the difficulty of arranging for transportation. In locating the center permanently in Harrisburg, those responsible were acting on the conviction that because most people prefer to help themselves and will make sacrifices to obtain good services, they would make use of the therapeutic tool created by distance.

Experience seems to be proving that the publicly supported, nontraveling child-guidance center serving rural areas is a sound plan. More than 75 percent of the children seen at the center have come from rural areas at their own expense. Recently a nearby community has provided a fund for transportation of those patients unable to afford their own transportation. In all, 776 children have received service at the center. They have come from 15 counties

and have been referred from 46 kinds of sources. Among them, in the order of their frequency, were schools, social agencies, institutions and hospitals, and parents whose children had received service at the center previously. The increase in the number of cases has been rapid but sound. The soundness is shown by the ever-increasing number of referrals from parents and individuals.

Another interesting trend, and one which seems to bear out that a need for complete psychiatric services for children exists in rural areas, is the increasing proportion of cases in which psychiatric treatment is sought. Although at first two-thirds of the applications were requests for psychological service, applications for psychiatric treatment are now greater in number than for any other given service. Excluding cases in which consultation is requested, about 19 applications per month are made for direct service to children. Of these, 47 percent are requests for psychiatric treatment; 42 percent, for psychological service; and the remaining 11 percent, for diagnostic study.

Whereas none of the changes and trends noted may be regarded as final conclusions, they do seem to point out that there are practical aspects of the need for children's psychiatric services in rural areas which can be met by a permanently located child-guidance clinic.

BOOK NOTES

General Child Welfare

State publications Among publications recently received from State departments and organizations may be noted the following:

BIENNIAL REPORT OF THE BUREAU OF NEGRO WELFARE AND STATISTICS, STATE OF WEST VIRGINIA, 1939–40. Charleston, W. Va., 1940. 140 pp. This, the fourth biennial report of the Bureau of Negro Welfare and Statistics, compiles facts and statistics regarding the Negro in West Virginia. The last 48 pages contain the proceedings of the West Virginia State Conference on the Welfare of the Negro, held in May 1940. The conference was divided into sections to consider health, education, vocations and occupations, employment, State institutions, race relations, child welfare, housing, and legislation. Each committee presented recommendations for solving some of the basic problems which were considered.

AID TO DEPENDENT CHILDREN IN THEIR OWN HOMES. Part 1 of this bulletin, issued by the Division for Children, State Department of Social Security, for the State of Washington (Olympia, Wash.), issued November 1940, describes the Program for Aid to Dependent Children in Washington; part 2 tells how the program operates.

SPECIAL SERVICES FOR CONNECTICUT'S CRIPPLED PERSONS; a directory, 1941. Connecticut Society for Crippled Children, 65 Wethersfield Avenue, Hartford, Conn. 17 pp. This directory is divided into three sections: Local facilities for orthopedic care and education, State-wide public and private services, and glossary of terms.

Public Affairs Pamphlets Recent additions to the series of 10-cent pamphlets issued by the Public Affairs Committee, 30 Rockefeller Plaza, New York, are the following:

AMERICA'S CHILDREN, by Maxwell S. Stewart (1940, 31 pp.), a summary of the reports on the White House Conference on Children in a Democracy, January 1940.

AMERICA AND THE REFUGEES, prepared by Louis Adamic (1940, 32 pp.), which discusses the possibility of extending or limiting the immigration quotas and the difficulties of employment and assimilation as they affect both the country and the refugees.

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CHILD WELFARE SERVICES UNDER THE SOCIAL SECURITY ACT. Child Welfare League of America, 130 East Twenty-second Street, New York, April 1940. 40 pp. 45 cents.

This is a report of local child-welfare services in the State of Oregon prior to December 1939 and has been published by the Child Welfare League of America for the convenience of member agencies and organizations interested in programs for children. The report is intended to cover content of local services to children rather than methods of administration and organization.

THE SKILLS OF THE BEGINNING CASE WORKER, AS EVALUATED BY THE SCHOOL, THE AGENCY, AND THE WORKER. Family Welfare Association of America, 122 East Twenty-second Street, New York. 30 pp. 30 cents.

The three papers contained in this pamphlet were delivered at the meeting of the case-work division of

the National Conference of Social Work, May 28, 1940, at Grand Rapids, Mich.

SEX EDUCATION; FACTS AND ATTITUDES. Child Study Association of America, 221 West Fifty-seventh Street, New York, 1940. 64 pp. 35 cents.

These eight brief articles have been chosen by the Child Study Association to answer parents' questions about sex and sex education. They are intended to offer suggestions and guidance to the mature parent in search of his own philosophy. Except for the article, Concerning Masturbation, which was prepared especially for this publication, the papers are reprinted from *Child Study* and other magazines. A list of books on sex education is included.

A CITIZEN'S GUIDE TO PUBLIC HOUSING, by Catherine Bauer. Vassar College, Poughkeepsie, New York, 1940. 90 pp. 60 cents.

The author, Rosenberg lecturer at the University of California, was formerly Director of Research for the United States Housing Authority. She discusses the background of the housing question and the status of present housing programs, and offers answers to questions frequently met regarding the purpose, value, and practicability of public housing programs.

REPORT OF THE COMMISSIONER FOR THE UNITED STATES GOLDEN GATE INTERNATIONAL EXPOSITION COMMISSION, 1939–1940. Office of the Commissioner, San Francisco, Calif., 1941. 66 pp. plus photographs and tables. Processed.

This is a report, submitted by George Creel, United States Commissioner to the United States Golden Gate International Exposition Commission, on the participation of the Federal Government in the exposition. One-half of the report describes the services and exhibits of the agencies, including Children's Bureau activities in the fields of child health and child labor; one-fourth consists of photographs of the buildings and exhibits; and one-fourth, of financial statements.

Recreation and Community Organization

References on recreation

In a pamphlet entitled "RECREATIONAL RESEARCH" (1940; 63 pp.) G. M. Gloss has brought together references to some 300 books, theses, and dissertations on the subject. The discussion is arranged so that the contribution of each item to the literature is indicated briefly. Copies may be purchased from the author (G. M. Gloss, Associate Professor, School of Health, Physical Education and Recreation, Louisiana State University, Baton Rouge, La.) at $1 each.

Recreational personnel standards

SECURING AND MAINTAINING STANDARDS IN COMMUNITY RECREATION PERSONNEL is the title of a Report of the Committee on Standards of Training, Experience, and Compensation in Community Recreation Work of the National Recreation Association (315 Fourth Avenue, New York, 1940. 15 pp. 15 cents).

The recommendations and procedures suggested in this report are related to the earlier publication of the same committee, entitled "Standards of Training, Experience, and Compensation in Community Recreation Work."

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THE ADMINISTRATION OF PUBLIC RECREATION,[1] by George Hjelte. Macmillan Co., New York, 1940. 416 pp. $3.

The author, who is superintendent of recreation, City of Los Angeles, and was formerly Superintendent of Recreation, Westchester County, New York, has had a long career in recreation. He explains that the book is intended primarily as a textbook for use in college courses for those who are preparing to be recreation workers and executives. It is designed also to serve as a reference book for administrative officials and boards on the administration of recreation under systems of local government.

The subject matter is divided into three major parts, "Administrative Organization and Relationship of Recreation," "Administration of a Recréation Department," and "Related Problems of Recreation Administration."

The growth of recreation as a new function of municipal government is traced and the nature of the function is discussed. Various types of organization for recreation under municipal control are studied and the work of boards and councils as well as that of the recreation superintendent is considered in detail.

It is suggested that the schools of the future may be one type of agency through which recreation will be administered, since the more progressive schools are already organizing activities in nearly every field of leisure-time interest. Arguments are marshalled for and against school-centered programs, and the present status of such programs is discussed.

A brief report on county and rural recreation discusses the fact that public recreation is a new movement in rural areas and prophesies that it will probably "evolve through the established agency for public education in rural districts or through county governing boards and agencies established by them" with probable State and Federal aid. The functions of county and school districts are outlined and recreation projects now in operation are described.

Mr. Hjelte has called upon his years of experience in discussing such problems as accounting and financial procedure, budget making, line and staff organization, records and reports. There are brief sections on program planning, leadership, and supervision. The emphasis of the book generally, however, is placed, as the title indicates, upon the field of administration.

[1] Reviewed by Ella Gardner, Recreation Specialist, Extension Service, U. S. Department of Agriculture.

MEET THE GANG; HOW THE Y. M. C. A. BY ITS FAMILY POLICIES AND GANG PROGRAMS SERVES BOYS FORCED TO LIVE IN UNDERPRIVILEGED NEIGHBORHOODS. Association Press, 347 Madison Avenue, New York, 1941. 72 pp. 50 cents.

That "boys in trouble point up a neighborhood problem," is the premise on which this digest is based. The material was brought together by Charlotte Himber, a psychologist working as research assistant in the Boys' Work Department of the National Council of Young Men's Christian Associations, from questionnaires, pamphlets, records, and reports forwarded by local associations to the National Council. Included are references to the literature on underprivileged boys.

The approach outlined is primarily that of preventing delinquency through community study, organization, and activities.

A GUIDE TO COMMUNITY COORDINATION; FOR COORDINATING COMMUNITY, AND NEIGHBORHOOD COUNCILS IN CITIES AND TOWNS UNDER 25,000 IN POPULATION. Coordinating Councils, 145 West Twelfth Street, Los Angeles, Calif., 1941. 21 plus vii pp. 25 cents.

In response to requests Coordinating Councils has published this manual of specific data on establishing councils to coordinate efforts for community service. The emphasis is not on the organization or administration of agencies but rather on the coordination of efforts of many agencies and groups in improving community conditions and meeting community needs.

Mental Development

INTELLIGENCE: ITS NATURE AND NURTURE. THIRTY-NINTH YEARBOOK OF THE NATIONAL SOCIETY FOR THE STUDY OF EDUCATION, edited by Guy Montrose Whipple. Public School Publishing Co., Bloomington, Ill., 1940. Part 1, 471 pp., $2.25 in paper. Part 2, 409 plus xxxvii pp., $2.25 in paper.

In his preface the editor refers to the current Yearbook of the National Society for the Study of Education as the "Stoddard Yearbook" and considers it sequential to the "Terman Yearbook" published in 1928, which also discussed nature and nurture and their influence on intelligence and achievement. Part 1 of the present issue, Comparative and Critical Exposition, provides the reader with varying viewpoints as presented by a group of eminent psychologists on the subject, whereas part 2, Original Studies and Experiments, presents researches either in detail or through fairly substantial summaries.

The treatment of the subject is technical and difference of opinion is frequently evident, but high professional competence prevails throughout and criticisms of methods and results as well as interpretations are set forth without personalities or rancor.

Dr. Stoddard, who served as chairman of the Society's Yearbook Committee, explains that a "democratic method" has been followed in that almost all new material available has gone in and almost nothing has been kept out. This has meant that the yearbook has provided expositions of the issues that seem important but that no fundamental conclusions are drawn and that there is no single document which is endorsed or criticized in clear and systematic fashion.

An imposing group of about 50 persons contributed to the yearbook discussions. The wide divergence in their views may occasionally prove puzzling but will undoubtedly stimulate the reader to further study.

The individual appraisal of the yearbook by the members of the Yearbook Committee is most interesting as representing their personal views of various papers included in the report.

M. R. C.

FEEBLEMINDED CHILDREN AS A MASSACHUSETTS PROBLEM, by Jennette R. Gruener, Ph. D. Massachusetts Child Council, 41 Mount Vernon Street, Boston, 1941. 63 pp.

Dr. Gruener's brief report grew out of the interest of the Massachusetts Child Council in State resources for mentally retarded children. It is a discussion of present resources and methods of providing school and community care for these children and an attempt to acquaint the general public in Massachusetts with some of the pertinent problems "incident to effective provision for the mentally deficient" and with the responsibility of the community toward these problems.

Even though the report is confined to conditions in Massachusetts its findings could be of considerable interest to other States where institutional provisions may also be inadequate with the result that long waiting lists have been built up, where the training given in public-school classes has not been coordinated with a community program after the child leaves school, where the problem of the psychotic defective and the defective delinquent is a real one, and where better coordinated community planning is greatly needed.

Some general recommendations are made which the author considers obvious steps toward the achievement of more effective State planning and increased community responsibility for mentally defective children.

A short list of suggested readings relating to the mentally defective is included.

• CHILD LABOR •
• YOUTH EMPLOYMENT •
• VOCATIONAL OPPORTUNITIES •

Hearing on Proposed Hazardous-Occupations Orders for Logging and Sawmilling and Woodworking Machine Employment

Public hearings have been announced by the Children's Bureau of the United States Department of Labor, for May 28, 1941, to consider two proposed orders under the Fair Labor Standards Act of 1938, one declaring occupations in the logging and sawmilling industries and the other declaring occupations involved in the operation of power-driven woodworking machines to be particularly hazardous for minors between 16 and 18 years of age. If adopted, the orders will have the effect of applying an 18-year minimum-age standard for employment of minors in these occupations under the act.

The proposed order that concerns logging and sawmilling declares as hazardous for minors between 16 and 18 years of age "all occupations in logging and all occupations in any sawmill, lath mill, shingle mill, or cooperage-stock mill," but excepts from its provisions work in offices and repair and maintenance shops, work in the operation and maintenance of living quarters, work in timber cruising, surveying, or logging-engineering parties, work in forest protection, and work in the feeding or care of animals used in logging.

Work in timber culture or timber-stand improvement is not classed as a logging occupation and is not covered by the order, nor is work in emergency fire fighting in the event of forest fires. The order covers logging of pulpwood when pulpwood is logged in connection with the logging of timber for other uses, but it does not cover pulpwood logging where pulpwood only is logged. A later study of the hazards of pulpwood logging is planned in conjunction with a study of the hazards of pulp and paper making.

The proposed order dealing with woodworking-machine occupations declares that the occupations of operating power-driven woodworking machines are particularly hazardous for minors between 16 and 18 years of age. These occupations include feeding material into power-driven woodworking machines, helping an operator to feed material into them, or having direct control or supervision over such machines. The occupations of setting up, adjusting, repairing, oiling, and cleaning such machines are also classed as particularly hazardous as are the occupations of off-bearing from circular saws and from guillotine-action veneer clippers where such off-bearing is done directly from a saw table or from the point of operation.

The term "power-driven woodworking machines" is defined to mean "all fixed or portable machines or tools driven by power and intended for cutting, shaping, forming, surfacing, nailing, stapling, wire stitching, fastening or otherwise assembling, pressing, or printing wood or veneer."

The proposed order covers woodworking-machine occupations in all establishments subject to the child-labor provisions of the Fair Labor Standards Act.

Although the order covers off-bearing from circular saws and guillotine-action veneer clippers when such off-bearing is done directly from a saw table or from the point of operation, it is

not intended to cover workers engaged in removing material or refuse from these machines where such material or refuse has been conveyed away from the saw table or point of operation by some mechanical means or by a gravity chute, nor is it intended to apply to workers engaged in moving materials from one machine to another or one part of a plant to another by hand or by truck, nor to workers engaged solely in piling or stacking materials, nor to workers sorting, tying, or loading materials.

The proposed findings and orders are based on careful investigations by the Children's Bureau of the industries and occupations and on extensive consultation with safety experts and representatives of employer and labor groups. The findings of the investigations are presented in two reports, The Hazards of Logging and Sawmilling Employments for Young Workers and The Hazards of Woodworking-Machine Employments for Young Workers, which are available upon request from the Children's Bureau, United States Department of Labor, Washington, D. C.

If the proposed orders are adopted, employers should keep on file certificates of age for all 18- and 19-year-old minors employed in all hazardous occupations, as well as certificates for all 16- and 17-year-old minors employed in occupations not declared hazardous. Through cooperative plans developed by the Children's Bureau with State offices administering child-labor laws, State employment or age certificates are accepted as certificates of age under the Fair Labor Standards Act. The act provides that if an employer keeps on file a certificate of age, issued in accordance with regulations of the Chief of the Bureau, showing that a minor employee is above the minimum age established for the occupation in which he is to be engaged, the employer is protected from unintentional violation of the minimum-age provisions of the act.

As the proposed order is to be issued under the Federal Fair Labor Standards Act, it will apply only to employers who are engaged in the production of goods that are shipped or delivered for shipment in interstate commerce. In the case of employers not covered by the act the minimum-age standards of the State child-labor law prevail, and even for employers who are covered by the act the State standard prevails whenever it is higher than the Federal standard.

Child Workers in the Berry and Bean Fields of Erie County, New York

During the summer of 1940 the New York State Department of Labor sent inspectors to Erie County to visit a sample group of berry and bean farms where seasonal workers were employed in order to obtain data on agricultural labor. On the 100 farms visited a total of 3,670 workers were employed.

This study was made at the request of Buffalo social agencies, which for some time had been concerned with the problems involved in the migration of family groups from Buffalo to work on commercial farms in the harvesting of crops. Joining in the request was the State Committee on Summer Farm Problems, which has long sought to regulate child labor on commercial farms throughout New York State.

The laboring group working in the harvesting of berries and beans was composed chiefly of women and children from the city of Buffalo, who went to the farms for the picking season and lived in labor camps. Of the 3,670 workers engaged in picking berries and beans on the 100 farms 2,156 were under 18 years of age. In fact, 1,070 of them were children under 14 years

of age. Table 1, presenting the age distribution of these workers, shows that 9 percent of all the workers on these farms were under 10 years of age.

Age of hired workers engaged in picking berries and beans on 100 farms in Erie County, N. Y., summer 1940

Age	Hired workers	
	Number	Percent distribution
Total	3,670	100.0
Under 14 years	1,070	29.2
Under 10 years	330	9.0
10 and 11 years	316	8.6
12 and 13 years	424	11.6
14 and 15 years	559	15.2
16 and 17 years	527	14.4
18 years or over	1,514	41.2

Boys and girls were about equally represented among the workers under 18 years of age, but among those 18 or older the women of the families predominated, 934 women to 580 men.

Conditions of the summer's work for these families were trying, not only because of the long hours in the hot sun—a 10-hour day apparently was common—but also because conditions of sanitation and decency in the labor camps were far from satisfactory. Rules of the State Department of Labor governing conditions of cannery labor camps are not applicable to labor camps on farms, but the New York State Department of Labor found such bad conditions in the 88 labor camps visited that orders to correct 1,117 violations would have been issued had the rules been applicable.

The New York State Department of Labor comments with respect to the findings of this study that "it may appall citizens of a good labor-standards State like New York . . . to know that there is still as much child labor here as this spot study would indicate. Commercial agriculture, with the exception of street trades, is the last serious child-labor problem in the State . . . The Labor Department is not opposed to young people of proper age and under proper conditions 'digging in the dirt' for hire, . . . but 8-year-olds toiling in the hot sun for 10 hours a day is certainly not conserving manpower for future industry." [1]

[1] Release for January 10 and 11, 1941. Labor Publications Editor, New York State Department of Labor.

BOOK NOTES

American Youth Commission publications

A number of recent publications prepared for the American Youth Commission and obtainable from the Commission (744 Jackson Place, Washington, D. C.) deal with closely related problems affecting the occupational and vocational adjustment of young people, especially in rural areas. Among these publications may be mentioned:

GUIDEPOSTS FOR RURAL YOUTH, by E. L. Kirkpatrick (American Council on Education, Washington, 1940, 167 pp., $1). This book is concerned chiefly with finding a solution to the serious problems faced by rural youth. It records what many rural counties, towns, and organizations are already doing toward solving the youth problem locally, and in its analysis of the problem it brings to light basic principles of a practical program for its solution. Among these principles are: that the most successful enterprises are begun with surveys which provide a basis for intelligent action; that the aims should expand as the program develops; that the program must be carried out by the participants, making the fullest possible use of local resources; and that the program must be cooperative, with the pooling of ideas, efforts, and experiences.

MATCHING YOUTH AND JOBS; A STUDY OF OCCUPATIONAL ADJUSTMENT, by Howard M. Bell (American Council on Education, Washington, 1940, 277 pp., $2). This report is based upon the findings and activities of a joint project carried on by the American Youth Commission and the United States Employment Service (now a part of the Bureau of Employment Security of the Federal Security Agency) to determine the needs of young people seeking jobs and to find ways of meeting these needs.

THE OCCUPATIONAL ADJUSTMENT OF YOUTH is an earlier, briefer statement based on the same material.

WORK CAMPS FOR HIGH SCHOOL YOUTH, by Kenneth Holland and George L. Bickel (American Council on Education, Washington, 1941, 27 pp., 25 cents), is the story of the experiences of 58 high-school boys and girls in 3 work camps in the summer of 1940. The camps were operated by a group, the Associated Junior Work Camps, made up of parents, teachers, and youth. The campers, except for a few who held scholarships, shared expenses of the camp, paying $125 apiece for the 8-week period. In addition, each camp was located where the campers could visit "problem areas" and learn at first hand about difficulties that confront youth on farms, in mining communities, and in industrial centers.

YOUTH-SERVING ORGANIZATIONS; NATIONAL NONGOVERNMENTAL ASSOCIATIONS, by M. M. Chambers (American Council on Education, Washington, 1941, second edition, 237 pp., $2.50) has been issued for the American Youth Commission because of continued requests. The first part comments on the role of private associations in American life, suggest further studies, and present some statistics relating to membership and budget. The second part is a descriptive inventory of 320 organizations, 81 of which are classified as "youth-membership" societies and 239 as "adult associations serving youth." Information is given concerning membership, purpose, activities, publications, staff, and finances.

THE COMMUNITY AND ITS YOUNG PEOPLE, by M. M. Chambers (American Council on Education, Washington, 1940, 36 pp., 15 cents), is designed for community leaders and for public-spirited parents and youth. In it are discussed the contributions that local communities can make to solving the youth problem.

• EVENTS OF CURRENT INTEREST •

Date Set for Pan American Child Congress

March 28 to April 4, 1942, is the date set for the Eighth Pan American Congress. The Congress will be held in Washington, D. C.

The Secretary of State has designated Katharine F. Lenroot, Chief of the Children's Bureau, as Chairman of the Organizing Committee for the Congress. Miss Lenroot is a member of the Council of the International American Institute for the Protection of Childhood.

Members of the Organizing Committee are:

William G. Carr, Ph. D., director of research, National Education Association, Washington, D. C.

Henry F. Helmholz, M. D., professor of pediatrics, Mayo Foundation of the University of Minnesota, Rochester, Minn.

Warren Kelchner, Ph. D., Chief, Division of International Conferences, Department of State, Washington, D. C.

The Reverend Bryan J. McEntegart, director, division of children, Catholic Charities of the Archdiocese of New York, New York, N. Y.

Thomas Parran, M. D., Surgeon General, Public Health Service, Federal Security Agency, Washington, D. C.

John W. Studebaker, LL. D., Commissioner, United States Office of Education, Federal Security Agency, Washington, D. C.

Elisabeth Shirley Enochs of the Children's Bureau has been designated Secretary to the Committee.

Recommendations as to Children Adopted by Social-Service Conference

Recommendations based on the principles of the White House Conference on Children in a Democracy were adopted at the Conference To Maintain and Extend Social Services, which was held in New York, March 29, 1941, under the auspices of the student organization of the New York School of Social Work.

The five major areas with which the recommendations deal are:

The assurance of a livelihood for families and individuals.

The preservation and restoration of health.

The assurance for all children of suitable education and favorable conditions for growth and development.

Social services for children and adults who are at a disadvantage compared with their fellows.

The guarantee of real political, economic, and social equality, unhampered by restrictions upon creed, race, or color.

The recommendation as to children is as follows:

The White House Conference on Children in a Democracy has spoken clearly for all people on what is required to provide reasonable opportunities for all children of the country if they are to grow into adequate, happy, democratic members of the community. We heartily endorse the recommendations of the White House Conference on Children in a Democracy with respect to those services that come to children directly, such as education, vocational preparation, and welfare services, as well as those benefits which come indirectly by way of their parents and the community.

Among the measures necessary to provide for the future welfare of children are the assurance of livelihood to their parents, the prevention of disease and provision of medical services, a system of Federal grants-in-aid to States and the extension of State aid to localities for schools, libraries, recreation, and social services; also the final abolition of child labor throughout the land.

We specifically recommend the following:

(*a*) The expansion of child-welfare services under the Social Security Act.

(*b*) The passage of a law inaugurating Federal grants-in-aid to education.

(*c*) The ratification of the child-labor amendment. New York State is among those that have not ratified this amendment.

CONFERENCE CALENDAR

July 6–12	International Conference of the New Education Fellowship at the University of Michigan, Ann Arbor, Mich. Health Education Meetings have been organized by the Health Section of the World Federation of Education Associations in collaboration with the New Education Fellowship. For further information: Progressive Education Association, 221 West Fifty-seventh Street, New York, N. Y.
July 6–11	National Federation of Business and Professional Women's Clubs. Sixth biennial convention, Los Angeles, Calif. Permanent headquarters: 1819 Broadway, New York.
July 8–12	Association for Childhood Education, Forty-eighth annual convention, Oakland, Calif. Permanent headquarters: 1201 Sixteenth Street, NW., Washington, D. C.
July 13–18	American Physiotherapy Association. Twentieth annual convention, Stanford University, Calif. Permanent headquarters: 737 North Michigan, Chicago, Ill.
Aug. 10–13	International College of Surgeons, Mexico City, Mexico.
Sept. 15–19	American Hospital Association, Atlantic City, N. J.
Sept. 15–21	Second Inter-American Congress of Municipalities, Santiago, Chile.
Oct. 9–11	American Academy of Pediatrics, Boston, Mass. In charge of arrangements: Dr. Clifford Grulee, 636 Church Street, Evanston, Ill.
Oct. 14–17	American Public Health Association. Seventieth annual meeting, Atlantic City, N. J. Permanent headquarters: 1790 Broadway, New York.

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